STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DINC	00	COMPL	ETED
			A. BUII B. WIN			07/05/	2012
			b. Will		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	1			ATERS EDGE PKWY		
WINDSO	D DIDGE				RSONVILLE, IN 47130		
WINDSO	K KIDGE			JEFFER	ASONVILLE, IN 47 130		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R0000							
	This visit was for	r a State Residential	R00	000			
	Licensure Surve	V			Submission of this Plan of		
	Enomination Surve.	, .			Correction does not constitute		
	Survey dates: Jul	l 2 2 5 2012			Admission or an agreement by		
	Survey dates. Jul	19 2, 3, 3, 2012			the provider of the truth of fact		
					alleged or corrections set forth the statement of deficiencies.	ON	
	Facility number:	004001			the statement of denciencies.		
	Provider number	: 004001					
	AIM number: N	r/A					
					The Plan of Correction is		
	Survey teem:				prepared and Submitted becar	use	
	Survey team:	N. T.C.			of State and Federal law.		
	Donna Groan, R						
	Dorothy Watts, I	RN					
	Census Bed Type	e:			Please accept this Plan of		
	Residential: 33				Correction as our credible		
	Total 33				allegation of compliance.		
	10001						
	Camana Darram Tr						
	Census Payor Ty	pe.					
	Other: 33						
	Total 33						
	Sample: 07						
	Supplemental sar	mple: 04					
	~						
	Those state resid	ential findings are cited					
		•					
	in accordance wi	th 410 IAC 16.2.					
	Quality review c	ompleted 7/10/12 by					
	Jennie Bartelt, R	N.					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

State Form Event ID: BFIH11 Facility ID: 004001 If continuation sheet Page 1 of 12

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/30/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC	00	COMPLETED			
			B. WING			0/2012		
NAME OF P	ROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP COI	DE			
WINDSO	R RIDGE		2700 WATERS EDGE PKWY JEFFERSONVILLE, IN 47130					
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	CTION	(X5)		
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE		

State Form Event ID: BFIH11 Facility ID: 004001 If continuation sheet Page 2 of 12

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJII	DING	00	COMPL	ETED
			A. BUII B. WIN			07/05/	2012
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ATERS EDGE PKWY		
WINDSO	R RIDGE		JEFFERSONVILLE, IN 47130				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
				TAG	DEFICIENCY)		DATE
TAG R0273	410 IAC 16.2-5-5 Food and Nutritio (f) All food prepa (excluding areas maintained in acc sanitation and sa including 410 IAC Based on observa the facility failed policy was follow observation durin This deficient pra affect 33 resident facility. Findings include On 7/2/12 between p.m., the followin #1 was observed	onal Services - Deficiency ration and serving areas in residents ' units) are cordance with state and local afe food handling standards, C 7-24. ation and record review, to ensure a hand hygiene wed for 1 of 1 mg meal preparation. actice had the potential to ts who reside in the	R02	73	1. No residents were harmed Cook #1 was immediately re-educated on the facility's Handwashing policy. 2. All residents have the potential to affected. 3. All dietary staff habeen in-serviced on the facility Handwashing policy, (see attachment A). As a measure ensure ongoing compliance, the Dietary Manager or designeers complete an audit daily on regularly scheduled days for 1 month, then twice weekly for 1 month, then weekly for 1 month monthly thereafter to enshands are washed per facility	be ve 's to ne will h,	07/18/2012
	obtaining a temp and cheese and re	he hand washing. After erature for the macaroni eturning it to the oven,			policy, (attachment B). 4. As a measure of quality assurance the Dietary manager will complete the above described monitoring		
	and proceeded to	unter top with sanitizer the garbage can and			ongoing on a monthly basis. Should a deficient practice be observed, immediate correctiv	e	
		h her hands. Time of 5			action will be taken. The		
	procedure.	during the handwashing			Administrator will monitor and sign off on the monitoring tools a monthly basis ongoing. The		
	Manager provide Policy for the Di- policy included,	o p.m., the Dietary of the Hand Washing etary Department. The but was not limited to: Hands are washed c.			plan of correction will be revise accordingly, if warranted.	ed	

State Form Event ID: BFIH11 Facility ID: 004001 If continuation sheet Page 3 of 12

	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/05/2012
	PROVIDER OR SUPPLIER OR RIDGE	2700 W	ADDRESS, CITY, STATE, ZIP CODE ATERS EDGE PKWY RSONVILLE, IN 47130	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE COMPLETION
	After taking out garbage, putting away stock, cleaning 2. Handwashing Procedure: d. Hands must be washed for a minimum of 20 seconds."			
	On 7/2/12 at 3:15 p.m., the Residential Care Administrator provided the facility Handwashing/Hand Hygiene Policy and Procedure revised 3/07 which included, but was not limited to: "Handwashing Procedure:5. Lather all areas of hands and wrists, rubbing vigorously. Wash between your fingers, the backs of your hands, your palms, and around your fingernails. Continue this scrubbing action for at least ten seconds. Clean your nails by rubbing them in the palm of your other hand. Please note, food service employees shall perform this scrubbing action for at least 20 seconds."			

State Form Event ID: BFIH11 Facility ID: 004001 If continuation sheet Page 4 of 12

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY				URVEY			
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00		COMPLE	ETED
			B. WING			07/05/2	2012
			_	ET ADDRESS, CITY,	STATE ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	S.) WATERS EDG			
WINDSO	R RIDGF			FERSONVILLE,			
(X4) ID		TATEMENT OF DEFICIENCIES	ID		ER'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFI		RENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)		DATE
R0298	410 IAC 16.2-5-6	o(c)(z) Services - Deficiency					
		pharmacist shall be					
	` '	der contract, and shall:					
	• •	le for the duties as specified					
	in 856 IAC 1-7;						
		rug handling and storage					
	practices in the f	acility;					
	, , ,	ultation on methods and					
	procedures of or						
		nd disposing of drugs as well					
	as medication record keeping; (D) report, in writing, to the administrator or						
(D) report, in writing, to the administrator or his or her designee any irregularities in							
dispensing or administration of drugs; and							
		rug regimen of each resident					
		services at least once every					
	sixty (60) days.	•					
	Based on record	review and interview, the	R0298	1. Resider	nt #4 was not harm	ed.	07/18/2012
		ensure a resident's drug			acy Consultant had		
	-	iewed by the pharmacist			reviewed resident #4's medication		
	every 60 days for	2 2		_	ery 60 days. 2. A ave the potential to		
	reviewed for dru	g regimen review by		affected. Al	l residents have ha		
		imple of 7. (Resident #4)			ation regimen		
	, , , , , , ,	•			y the consultant		
	Findings include			1 '	. 3. The DON has ucated on the	3	
	i mamga merade	•			Pharmacist visit		
	The clinical reco	rd for Resident #4 was			recommendations	,	
					t C). The Pharmac		
		12 at 9:10 a.m. The			report includes any		
		the resident was admitted			dations being made		
	to the facility on	5/21/11. Documentation			esidents that have	had	
	was lacking of a	pharmacist drug regimen		reviewed w	ation regimens		
	review for the me	onths of October and			dations made. The		
	December 2011,	February and April,			signee will complete	_e	
	2012.				th each consultant		
				report to en	sure the Consultar	nt	
	In intervious with	n the Residential Care			has reviewed all		
	III IIIICI VICW WILL	i die residendal Cale		residents' n	nedication regimen	s at	

State Form Event ID: BFIH11 Facility ID: 004001 If continuation sheet Page 5 of 12

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/30/2012 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPI	
			B. WING		07/05	/2012
NAMEOUR	DOMDED OF GLIDE TEL		STREET	ADDRESS, CITY, STATE, ZIP COI)E	
NAME OF F	PROVIDER OR SUPPLIER	(2700 W	/ATERS EDGE PKWY		
WINDSO	R RIDGE		JEFFE	RSONVILLE, IN 47130		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	CTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG			DATE
	Administrator or	n 7/3/12 at 9:32 a.m., he		least every 60 days, (atta		
	indicated the pha	armacist was just in the		D). 4. As a measure of assurance the DON will		
	other day, but co	ould not locate the visit in		the above described mor	•	
	the clinical recor	rd. At 10:20 a.m., he		ongoing on a monthly ba		
	indicated he cou	ld not find the		Should a deficient practic		
	documentation.			observed, immediate cor		
				action will be taken. The		
	On 7/5/12 at 10:	30 a.m., the Residential		Administrator will monito sign off on the monitoring		
	Care Administra			ongoing. The plan of cor		
		iew/Recommendations		will be revised according		
				warranted.		
	_	ised 11/08 which				
	included, but wa					
		Consultant Pharmacist				
	· -	ponsible for the periodic				
		ag regimen of each				
	resident for who	m the facility is				
	responsible for r	medication administration.				
	Review should b	e conducted at least				
	every 60 days."					
I	l		ı	i e		1

State Form Event ID: BFIH11 Facility ID: 004001 If continuation sheet Page 6 of 12

AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING (COMPLETED)				
			A. BUII B. WIN			07/05/	2012
	PROVIDER OR SUPPLIER		p. w.i.v	STREET A 2700 W	ADDRESS, CITY, STATE, ZIP CODE VATERS EDGE PKWY RSONVILLE, IN 47130		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
R0302	(6) Over-the-coulidentified with the (A) Resident name (B) Physician name (C) Expiration date (D) Name of drug (E) Strength. Based on observer record review the over-the-counter residents name as physician's name carts observed. (In the carts observed.) Findings include 1. On 7/3/2012 are reviewing the medication cart in the prescribing proposed bottle. One OTC resident's name rephysician's name rephysician's name rephysician's name rephysician's name redications were calcium + D 3, V. Aspirin 81 mg, C. Vitamins, and Proposed C. Resident #10 C. S00 mg with note that the prescribing proposed calcium is name redications.	Services - Deficiency Inter medications must be de following: Inc. Inc. Inc. Inc. Inc. Inc. Inc. Inc.	R03	002	1. Complete labels were place on the medication containers fresident #9, 10, 11, and 12. 2 All residents with OTC medications have the potentia be affected. All medication car were checked to ensure all medications have an appropria label in place. 3. All nursing sin-serviced on the facility's pol on Over-the —Counter medications, (attachment E). DON or designee will complete an audit weekly for 1 month, the every other week for one monthen monthly to ensure all medications have an appropria label, (attachment F). 4. As a measure of quality assurance DON will complete the above described monitoring ongoing a monthly basis. Should a deficient practice be observed immediate corrective action will be revised accordingly, if warranted. The Administrator will be revised accordingly, if warranted. The Administrator monitor and sign off on the monitoring tools on a monthly basis ongoing.	or I to ts ate staff icy The e nen th, ate the on	07/18/2012

State Form Event ID: BFIH11 Facility ID: 004001 If continuation sheet Page 7 of 12

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIP	LE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		00	COMPL	ETED
			B. WING			07/05/	2012
			STR	EET A	DDRESS, CITY, STATE, ZIP CODE	•	
NAME OF I	PROVIDER OR SUPPLIEF	R.	270	00 W	ATERS EDGE PKWY		
WINDSC	R RIDGE				RSONVILLE, IN 47130		
(X4) ID	STIMMADAS	TATEMENT OF DEFICIENCIES	ID		·		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFI	$_{\rm v}$	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TAC		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
1710		Egg BENTH THIS HI ORGANITION	1710				DATE
	name.						
		had two OTC medication					
	bottles with no la	abel identifying the					
	prescribing phys	icians's name. The					
	medications wer	e as follows: Melatonin 3					
	mg, Aspirin 81 r	ng.					
		-					
	4 Resident #12	had two OTC medication					
		abels identifying the					
		ician's name. The					
	medications wer						
		Iultiminerals Supplement					
	400 IU vitamin f	fiber Capsules,					
	Multivitamins.						
	The clinical reco	ords were reviewed on					
	7/3/2012 betwee	n 1:00 P.M. and 1:25					
	P.M. for Resider	nts #9, #10, #11, and #12,					
		ad current medication					
	1	physicians for the above					
		ons. In interview with					
	· ·	ime, she indicated the					
	medications belo	onged to the residents.					
	The Facility Poli	icy and Procedure for					
	Over-The-Count	er Medications, provided					
	by the Residentia	al Care Administrator					
	was reviewed on	7/3/2012 at 1:06 P.M.					
		ncluded, but was not					
	_	hand written legible label					
		_					
	placed by license						
		ontainer/bottle shall					
	include the follo	wing: Resident Name and					

State Form Event ID: BFIH11 Facility ID: 004001 If continuation sheet Page 8 of 12

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/30/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO A. BUILDING B. WING	00	— COM	e survey Pleted 15/2012
	PROVIDER OR SUPPLIER	-	2700 W	ADDRESS, CITY, STATE, ZIP C VATERS EDGE PKWY RSONVILLE, IN 47130	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
IAU	On 7/3/2012 at 1 interview with L	e." 2:45 P.M., during an PN # 1 she indicated all tions need to have a label 's name and the	IAG	DIA CLEACT)		DATE

State Form Event ID: BFIH11 Facility ID: 004001 If continuation sheet Page 9 of 12

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE : COMPL 07/05/	ETED
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE ATERS EDGE PKWY RSONVILLE, IN 47130		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
R0354	(g) A transfer for (1) Identification (2) Name of the (3) Name of the (3) Name of the (4) Resident 's ptransferred to an (5) Nurses' note (A) functional abilimitations; (B) nursing care; (C) medications; (D) treatment; an (E) current diet a (6) Diagnosis. (7) Date of chest tuberculosis. Based on record facility failed to swhich included in the resident, and limitations, date test for tuberculo they were transfer. This deficient praresidents reviewed sample of 7 residents reviewed sample of 7 residents included in the resident #7, and Findings include. 1. The clinical rewas reviewed on resident was sent included on resident was sent included.	- Noncompliance m shall include the following: data. transferring institution. Transferring institution and date described institution and physical described institution and skin test for described institution and skin described institution and skin described institution and date date date date date date date dat	R03:	54	1. No resident was harmed related to the transfer sheet documentation.2. All residents being transferred to another facility/home have the potentia be affected.3. All nursing staff in-serviced on completing the transfer sheet completely, (attachment G). The DON or designee will complete an aud tool weekly for 1 month, then every other week for 1 month, then monthly to ensure all transfer forms are completed thoroughly, (attachment H).4. a measure of quality assurance the DON will complete the abordescribed monitoring ongoing a monthly basis. Should a deficient practice be observed immediate corrective action will be taken. The plan of correction will be revised accordingly, if	As e ove on	07/18/2012

State Form Event ID: BFIH11 Facility ID: 004001 If continuation sheet Page 10 of 12

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPL	ETED
			A. BUII			07/05/	2012
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE		
MINIDOO	D DIDOE				ATERS EDGE PKWY		
WINDSC	R RIDGE			JEFFEF	RSONVILLE, IN 47130		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-	DATE
	Form was blank	for the following			warranted. The Administrator	will	
	information, whi	ich included, but was not			monitor and sign off on the		
	•	nal Hygiene, Dressing,			monitoring tools on a monthly		
		havior, Mental Status,			basis ongoing.		
	· ·						
		tion. The transfer sheet					
		ate of the chest xray and					
	last Mantoux (tu	berculosis test) with					
	results.						
	2. The clinical r	ecord for Resident #1					
	was reviewed on	7/2/12 at 2:15 p.m. The					
		t out to the hospital on					
		ent and evaluation for					
		The Transfer Form was					
	blank for the foll	lowing information:					
	Personal Hygien	e, Dressing, Locomotion,					
	Behavior, Menta	ll Status, and					
	Communication.	The Transfer Form also					
		of the chest xray and last					
		culosis test) with results.					
	Wiantoux (tuberc	ulosis test) with results.					
	0 7/5/10 : 0 :						
		5 a.m., in interview with					
	the Resident Car	re Administrator, he					
	indicated he wou	ald expect the nurses to					
	fill in the Transf	er Form completely.					
		· · ·					
	3. On 7/3/12 at	10:05 a.m., Resident #6's					
	chart was review						
		rge Summary dated					
		nk for the following					
		rsonal Hygiene, Dressing,					
	Locomotion, Bel	havior, Mental Status,					
	and Communica	tion. The form did not					
	have a date for the	he chest x-ray, dates and					
	1	J / ·····	1				

State Form Event ID: BFIH11 Facility ID: 004001 If continuation sheet Page 11 of 12

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/30/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	COMPLETED 07/05/2012
	ROVIDER OR SUPPLIER		2700 W	ADDRESS, CITY, STATE, ZIP CODE VATERS EDGE PKWY RSONVILLE, IN 47130	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
		antoux test and the es and limitations for the			

State Form Event ID: BFIH11 Facility ID: 004001 If continuation sheet Page 12 of 12